FOR DISCUSSION PURPOSES ONLY

CRITICAL ACCESS HOSPITAL
QUESTIONS AND ISSUES

The following matrix is a list of the most commonly frequently asked questions by small hospitals accessing the Critical Access Hospital program. Besides a shelter from the Balanced Budget Act many hospitals have concerns regarding the entering into a federal program that is very new with no history of performance. The purpose of the matrix is to address the many questions and issues brought up by other hospitals, but it is evident that the list is not inclusive of all the potential questions but rather a starting point.

The matrix consists of three columns. The first column addresses the question or issue of concern. The second column is intended to be used by the State to address the issues as designed or interpreted in their state health plan regarding Critical Access Hospital's. In the third column are responses from around the country and are mostly taken from the American Hospital Association web site regarding Critical Access Hospitals.

The matrix is not a test for the State Technical Staff but rather an instrument to be used to address questions and issues brought up in other states prior to potential Critical Access Hospital's addressing these questions. Some of these Questions/Issues may not be appropriate for Alaska and should be eliminated from the list. There may be other Questions/Issues that need to be added.

Question/Issue:	**States Position:**	**HCFA/National Position:**
Certification:		
Accreditation for CAH's, will they be surveyed like all other hospitals?	Yes, hospitals must be in compliance with state licensure requirements for General Acute Care Hospital or Rural Primary Care Hospital requirements and in compliance with the Medicare conditions of participation for Acute Care Hospitals prior to conversion. Surveys may be conducted annually.	CAH's all must be hospitals in compliance with the hospital conditions of participation prior to conversion to a CAH. Upon conversion, the CAH must be surveyed and certified according to the CAH conditions of participation, which are very different from the hospital condition.
Who will conduct the Survey?	Health Facilities Licensing & Certification (HFL&C)	All of the surveys of CAH's are to be conducted by HCFA through the state survey agencies
Is it required to be JCAHO accredited as a CAH?	No Deemed Status is available currently for CAH designation under Medicare. If Deemed Status does become available under Medicare, the State could waive licensure survey for a 12-month period following the date of the accrediting agency's	There is no current requirement other than that done by the state survey agency.

	survey.	
Do I have to give up JCAHO accreditation if I Become a CAH?	There would be no benefit for JCAHO accreditation for a CAH at this time.	As of July 1999, JCAHO has not applied to HCFA for deeming authority to survey CAH's.
Can small towns with a population of 5000 or less build a new hospital that will qualify as a CAH?	The hospital would have to be licensed under either of the two levels currently available and certified as an Acute Care Hospital under Medicare before conversion to a CAH.	The facility would have to be certified as a hospital prior to the conversion to CAH status.
What happens to the CAH status if a hospital builds a new facility on a new campus?	CAH status would remain as long as the hospital continued to meet requirements. The provider agreement would stay with the hospital in the new location. If the new facility is to replace the old, no new license is needed. However, a survey of the new facility would be conducted.	
Can a Clinic build a new facility and become a CAH?	The hospital would have to be licensed under either of the two levels currently available and certified as an Acute Care Hospital under Medicare before conversion to a CAH.	
What are the guidelines for how often a CAH's will require a Medicare survey for re-certification after they get certified?	They will receive an initial survey before conversion and again one year later. Following the second year, frequency of Medicare surveys will depend on HCFA mandates in the survey budget call letters. State licensure surveys will be conducted annually.	They will be surveyed one year after certification.
Are CAH's going to fall into the 10 to 20 percent Medicare now does or more often?	Yes…After the second year they will fall into the HCFA mandated survey percentages.	The same 10 to 20 percent will be the same as all facilities.
If a hospital is licensed as a CAH can they go back to a regular hospital licensure?	Yes, a facility could go back, but would have to meet the current licensure requirements for General Acute Care Hospitals or Rural Primary Care Hospitals.	Licensure is a State issue and would have to be addressed at the state level. A CAH may apply for Medicare certification as a new hospital provider. The hospital would be responsible for meeting all necessary requirements to reenter the program as a hospital instead of a CAH.
Will a hospital converting to CAH be given a different provider number?	Yes. It may be necessary to obtain a new Medicaid number as well.	Yes. CAH's is a field by itself and is in the 1300-1399 series for each state. If the CAH has swing beds, there will be an alpha

		designator "z" placed after the two-digit state code. 511301 or 51z301

Conversion:

If a hospital converts to a CAH and it wished to go back to being a hospital, it could as long as a full survey as a hospital finds them in compliance.

In this situation could the CAH to a hospital be surveyed using the 1967 edition of the LSC since the hospital would have met this edition requirements before November 26th, 1982, at which time it was a hospital?	A hospital that was surveyed under the 1967 edition of the LSC that converted to a CAH and then later asks to convert back to a hospital would be surveyed using the 1967 edition of the code. This will be the case unless a facility ceases business or there is a break in certification status.	A hospital that was surveyed under the 1967 edition of the LSC that converted to a CAH and then later asks to convert back to a hospital would be surveyed using the 1967 edition of the code.
If a hospital converts to a CAH and then decides it wants to reconvert to a hospital, is there a penalty for reconversion?	No State penalties.	A hospital that was surveyed under the 1967 edition of the LSC that converted to a CAH and then later asked to convert back to a hospital would be surveyed using the 1967 edition of the code.
Would all the grandfathered issues allowing the hospital to pass the LSC still be effect if the CAH elects to convert back to a hospital?	Facilities are grandfathered under an old LSC only as long as there is no break in Medicare certification. There must be continued participation. If the facility terminated but come back in later, they would come under the new codes.	Facilities are grandfathered under an old LSC only as long as they participate as something but come under the new codes if they terminate but come back in later.

Credentialing and Quality Assurance:

Although not required in the August 29, 1997, rule, a standard that requires all (including non-networked) CAH's to have agreements for credentialing and quality assurance through a PRO or other entity (485.641(b)(4)) was included in the May 12, 1998, PPS update.		
What is the status of this standard and how will it be enforced if another entity is unavailable or cost prohibitive?	Every CAH must do credentialing and quality assurance under an agreement with: (1) one hospital that is a member of the Network; (2) one PRO or equivalent entity: or (3) one other appropriate and qualified entity identified in the state rural health care plan. At this time there are no other qualified entities identified in the State plan.	HCFA has completed draft guidance for quality assurance and credentialing. Every CAH must do credentialing and quality assurance under an agreement with: (1) one hospital that is a member of the Network; (2) one PRO or equivalent entity: or (3) one other appropriate and qualified entity identified in the state rural health care plan. This agreement should be in writing but not required. This other entity could be another CAH. There is no federal regulation that it be a network hospital or a network member.
How will requests to extend the 96-hour average stay be reviewed? If reviewed concurrently, how will standards be enforced if the PRO or other entity does not respond in a timely fashion and denies a request after the stay has been extended?	Unauthorized extensions may result in deficiency citation. HCFA is reviewing its methodology for review of the 96-hour rule.	Extended stays are to be the rare exception, not the rule. Any extended stays bear the risk of being denied payment form Medicare. There is absolutely no guarantee that a waiver will be issued.
What is the status of the 96-hour rule is congress? A proposal has been made and passed both houses to make the rule an average.	The change to a 96-hour <u>average</u> LOS rule passed and has become law.	
Does the "Alaska Medical Staff Services" qualify as "another appropriate and qualified entity"	No	

under this program?		

Criteria:

If a hospital is licensed for a certain number of beds, and converts to CAH, does it have to give up the beds over 15?	Hospitals could keep the extra beds on their license if they did not "maintain" more than 15 acute care beds or more than 25 beds including swing beds.	HCFA expects a hospital to delicense any beds in e3xcess of 15 (or 25 with swing-bed approval). But in the 1997 interim final regulation, HCFA sated that in states with cumbersome CON laws, hospitals could keep the extra beds on their license if they did not "maintain" more than 15/25.
Some facilities have observation beds. Would these count toward the 15-bed acute limit?	Observation beds do not count as inpatient beds. CAH's should be aware that the policies on coverage of observation services in hospitals also apply to them.	Observation beds do not count as inpatient beds. CAH's should be aware that the policies on coverage of observation services in hospitals also apply to them.
Does the observation day count in the 96-hour limit?	No	No, the time a patient spends in an observation bed within that facility does not count in the limited inpatient stay of 96 hours. The FI can and will deny payment for medically unnecessary outpatient observation.
If a CAH has same-day surgery patients, are recovery patients counted toward the 15-bed limit for acute care patients?	Same-day surgery services are considered an ambulatory, outpatient service. Recovery patients would not be included in the 15-bed limit for acute patients.	Same-day surgery services are considered an ambulatory, outpatient service. Recovery patients would not be included in the 15-bed limit for acute patients.
Can CAH's designate rooms for Hospice patients? Will such rooms count toward the 15-bed limit if the patients were considered as an acute patient?	The State licenses hospice programs under AS 18.18. Hospitals that provide hospice services must have the program licensed. The question remains, if the facility provided inpatient hospice services, and had inpatient beds used exclusively for their separately licensed hospice program, would the hospice entity	A CAH may have an agreement with a Hospice to provide respite services in a few of their acute inpatient beds. The beds would count in the 15-bed limit. The designated beds could be utilized interchangeably as respite beds or acute inpatient care beds.

	be considered in the hospital's license or could the beds be part of the hospice license as in the case of separately licensed and certified co-located LTC beds? HCFA is looking at this issue.	
Does the 96-hour limit apply to inpatient Hospice patients?	The 96-hour stay limit would not apply when these beds are being used to provide respite care.	The 96-hour stay limit would not apply when these beds are being used to provide respite care.
Can CAH's have PPS exempt units?	CAH may not have PPS exempt units since the CAH is not a PPS hospital.	CAH may not have PPS exempt units since the CAH is not a PPS hospital.
Are distinct part NFs counting toward the 15 bed or 25 bed totals since it is not part of the CAH?	Beds in a distinct part SNF or NF do not count toward the 15 or 25 beds.	Beds in a distinct part SNF or NF do not count toward the 15 or 25 beds.
If the CAH has a psychiatric unit, will these beds count toward the 15-bed acute care limit and will the 96-hour limit apply?	All inpatient services provided by a CAH would have to stay within the limits of a total 15 beds or acute care used and the 96-hour length of stay requirements, regardless of the type of care that is provided. Exceptions: Hospice?? Respite HCFA is reviewing this issue.	All inpatient services provided by a CAH would have to stay within the limits of a total 15 beds or acute care used and the 96-hour length of stay requirements, regardless of the type of care that is provided.

Swing Beds:

What if a CAH enters the program without swing-bed services and decides to add them later? Would a survey be required?	It would be necessary to survey for compliance with the swing-bed requirements, as the CAH would be providing new services. This would also require the CAH have an active swing bed patient at the time of survey.	It would be necessary to survey for compliance with the swing-bed requirements, as the CAH would be providing new services. The CAH provider number would have a "z" added to reflect the addition of the swing beds.
Are swing beds cost-based reimbursed?	The swing bed rate is based on the weighted average Medicaid Nursing Facility payment rates for the previous calendar year. Each payment rate included in the calculation is based on the costs at the individual facility.	Payment for SNF level care in a swing-bed CAH is made as described in the regulations. The method described in that regulation is also the basis for payment for SNF level care in a swing-bed hospital. Under the swing-bed payment method, inpatient routine care is paid for at the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located.

		Ancillary services such as radiology and lab tests are paid for on a cost basis.
Are minimum data sets required for CAH's with swing-beds?	YES. CAHs **are required** to complete MDS assessment for patients receiving extended care services in a swing-bed. However, they are not required to download MDS data to the State MDS system at this time. The extension was given to acute care hospitals but did not include the CAH. The requirement 42 CFR 485.645(d)(6) requires the facility to complete the State specified Resident Assessment Instrument (RAI), which for Alaska is the Minimum Data Set (MDS) used in nursing homes.	YES. CAHs **are required** to complete MDS assessment for patients receiving extended care services in a swing-bed. However, they are not required to download MDS data to the State MDS system at this time. The extension was given to acute care hospitals but did not include the CAH. The requirement 42 CFR 485.645(d)(6) requires the facility to complete the State specified Resident Assessment Instrument (RAI), which is the Minimum Data Set (MDS) used in nursing homes.

Emergency Services:

The CAH is at full capacity with all beds occupied, due to the limitations on acute care beds.

How will COBRA (EMTALA) come into play if there is an emergency patient requiring admission, who is transferred?	The CAH has an EMTALA obligation to provide the screening/ stabilization it is capable of even if its beds are full. The fact is if the hospital is full to capacity then it does not have the capability of providing inpatient services at that time. The expectation is that the patient would be transferred. As a practical matter, no hospital will be cited for keeping an outpatient more than 48 hours if there is no safe way to transfer the patient.	The CAH has an EMTALA obligation to provide the screening/ stabilization it is capable of even if its beds are full. The fact is if the hospital is full to capacity then it does not have the capability of providing inpatient services at that time. The expectation is that the patient would be transferred. As a practical matter, no hospital will be cited for keeping an outpatient more than 48 hours if there is no safe way to transfer the patient.

96-Hours Length of Stay:

What if a hospital exceeds the number of acute care patients	If either situation were identified upon survey to have occurred	If either situation were identified upon survey to have occurred

allowed or exceeds the 96-hour inpatient limit?	without appropriate documentation of justification, it would be cited.	without appropriate documentation of justification, it would be cited.
Will the State Health Plan automatically adopt the 96-hour average stay rule?	Yes…. An amendment would be sent to HCFA for approval.	
How will the 96-hours be computed? Will they be actual hours or billing hours?	HCFA is currently reviewing and determining how the 96-hours will be computed. It has not yet been determined. Actual hours are most likely.	
How will the 96-hour average be calculated? Will there be a specific formula?	HCFA is currently reviewing and determining how the 96-hours will be computed. It has not yet been determined. Actual hours are most likely.	
Is there a need for a "frontier" period longer than the 96 hours?	This would take congressional approval	
Can CAH's have specialty bed designation such as obstetrics?	The level of patients they choose to treat will definitely be impacted, but the CAH may provide specialty services within the scope of the regulations.	The level of patients they choose to treat will definitely be impacted, but the CAH may provide specialty services within the scope of the regulations.

Rural Health Clinics:

Can a CAH have a Hospital Based Rural Health Clinic?	YES…. However, it is a question whether there would be an advantage. Reimbursement for RHCs is being revised under Medicare.	
If a Hospital Based Rural Health Clinic is allowed, How will it be reimbursed under CAH?	NO… It would be reimbursed under the RHC.	

Frontier Areas:

How is the CAH program different for frontier areas?	There are not any separate provisions for frontier areas. Implementation would be the same as any other area.	There are not any separate provisions for frontier areas. Implementation would be the same as any other area.
Can it be extended to higher functioning rural health clinics in bush areas?	No, the facility must be a hospital prior to designation as a CAH.	No, the facility must be a hospital prior to designation as a CAH.

Surgical Services:

Can a facility also have surgical departments?	Yes, the procedures should be of such that the patient would not be expected to stay in the hospital for more than 96-hours.	Yes, the procedures should be of such that the patient would not be expected to stay in the hospital for more than 96-hours.
Does a CAH need to have surgical services available 24 hours a day, or can they have specific hours in which surgery is performed?	They can have specific hours of operations for surgery services.	They can have specific hours of operations for surgery services.

Patient Transfers:

As the CAH is receiving cost based reimbursement, will the receiving facility be penalized in its reimbursement? When a patient has to be transferred from the CAH for acute treatment, what reimbursement will be paid to the receiving hospital? Will the receiving hospital get the full DRG, or a per diem?	Alaska Medicaid pays hospitals on a percentage of charges basis, not a DRG system. Therefore, when a patient is served in a hospital, Medicaid pays a percentage of all allowable charges applicable to the Medicaid patient. A receiving facility is not penalized.	The fact that a patient is admitted to a full service hospital from a CAH has nothing at all to do with what HCFA pays the full-service (receiving) hospital. The CAH is paid on a reasonable cost basis for its care. The receiving hospital is paid under PPS. The discharge/transfer rules in the regulations will apply to patients leaving a PPS hospital. So if the patient goes to another PPS hospital, the first PPS hospital gets a prorated amount, not a full DRG. But this would happen in any case; the fact that the patient originally came from a CAH is irrelevant.

Payment Systems:

Are Medicare managed care organizations required to pay CAH's on a cost basis?	N/A	No, the method of payment is negotiated between the managed care organization and the CAH.
Is the State Medicaid program participating in the same cost based reimbursement as the Medicare Program?	No. Medicaid payment rates are based on individual facility costs, but are prospective in nature using base year costs and inflation factors to calculate prospective rates.	This is left up to each state.
Will other state healthcare systems be required to pay CAH's on a cost basis?	No.	

Are CAH's reimbursed for both capital and operating expenses?	Yes.	Yes, as long as there are not signs of program abuse.
How are ambulance services treated in the cost report structure? Can the cost of ambulance equipment and personnel be reported and reimbursed in the CAH cost structure?	No. Reasonable cost payments to CAH's cover only the CAH inpatient and outpatient services, not ambulance services. Ambulance services are paid under a separate Medicaid system.	No. Reasonable cost payments to CAH's cover only the CAH inpatient and outpatient services, not ambulance services.
How will hospitals be paid while they are waiting for CAH conversion?	Hospitals will be paid the hospital payment rate while waiting to convert to CAH status.	Hospitals should still be paid the PPS rate while waiting to convert to CAH status.
When exactly does the payment system change?	The payment systems are currently indentical.	The date conversion takes effect.
Can CAH's receive disproportionate share payments? The DSH rules refer to days attributable to areas in a hospital that are subject to PPS, so are CAH's excluded?	Yes.	DSH payments are available only to hospitals paid under PPS. CAHs, which are a separate provider type and have their own payment rules, cannot get them.
Is there clarification on coinsurance amounts for CAH services based on hospital charges?	Coinsurance requirements are the same as for all hospitals.	Coinsurance amounts for CAH services are to be determined based on the hospital's charges, as in the case for full-service hospitals and most other providers.
Will there be a single national intermediary for CAHs as with other Medicare programs?	N/A	HCFA has not made a decision on the issue of a single intermediary.

Networks:

The rural health network must consist of at least one CAH and one full-service hospital, which should be in the same state as the CAH. The CAH must be located within the state however; the full service hospital could be located in another state. The state would need to justify the necessity for the network to be established in this manner.

Do all CAH's have to be in a network?	No, there is a requirement that at least one network is developed that includes one CAH and another full-service hospital.	No, there is a requirement that at least one network is developed that includes one CAH and another full-service hospital.

Is it the CAH's choice as to the full-service hospital they choose to network with?	Yes	
Could the CAH have a network relationship with two or more full-service hospitals?	Yes	

Staffing/Personnel Issues:

Will the CAH regulations allow physician's assistants and nurse practitioners to run emergency services with only phone availability of physicians, or with, for instances, availability on site within 30 minutes?	Yes, however, the State Rural Health Plan requires CAHs that downsize and have physician's assistants and nurse practitioners to run emergency services with only phone availability of physicians and availability on site within 30 minutes, the facility must include in their EMS plan how services will be provided so that patients arriving via ambulance will be met at the facility's ER by qualified hospital staff. It is the intent of the State that neither patients nor EMS personnel have to wait at the ER for hospital staff to arrive. The Department must approve the EMS plan in this instance.	Yes.
Is a certified nurse midwife eligible under the Certified Nurse Specialist category or another category?	Yes	Under the regulations, if a State recognizes a certified midwife as a certified nurse specialist, they would qualify.
If there are no patients in the acute care service, is a Certified Nurse required to be on duty?	No	

Definition of Reasonable Cost:

Reasonable cost is the actual incurred cost of furnishing a provider's services. This includes all necessary and proper costs of furnishing the services, as long as they are not substantially out of line with the costs of other, similar institutions in the area. For Medicare purposes, reasonable cost is determined in accordance with a well-established body of accounting and cost-finding principles, as set forth in the regulations and Provider Reimbursement Manual (HCFA pub. 15).

Which specific reasonable cost payment principles will be applied in determining payment to CAH's?	For Medicaid purposes, reasonable cost is determined in accordance with a well-established body of accounting and cost-finding principles, as set forth in state and federal regulations and the Provider Reimbursement Manual (HCFA pub. 15). State regulations (Alaska Administrative Codes) are contained in 7 AAC 43.685 and 686. The principles of the less of cost or charges are currently contained in the regulations. The methodology for applying ceilings on prospective payment rates is included in 7 AAC 43.685.	HCFA plans to apply the limits on physical, occupational, speech, and other therapy services furnished under arrangements in determining the reasonableness of cost of both inpatient and outpatient services. There is no plan to apply the principles of the less of cost or charges. There is no plan to apply ceilings on the rate of hospital cost increases or any type of reductions of operating ore capital costs. There is no plan to apply the blending of payment amounts for ambulatory surgical centers (ASC) services, radiology, and

	There is a small facility payment system in which Wrangell Hospital, Seward Hospital, Kodiak Hospital, and Sitka Hospitals participate. In this small facility system outpatient laboratory is paid on a facility specific percentage of charges. Other hospitals are paid outpatient lab based on the Medicare fee schedules.	other diagnostic services, or the clinical laboratory fee schedule. There is no plan to apply RCE limits on payments of physicians to providers. However, the cost of these services will be subject to both the prudent buyer principal and the requirement that costs not be "substantially out of line" with those of other similar institutions.